Commonwealth of Virginia

TO: Virginia Health Reform Initiative Advisory Council and Task Force Members

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DATE: April 15, 2011 **(Written comments on this Memorandum due <u>April 29, 2011</u>)**

SUBJECT: **First Background Memorandum on Health Benefit Exchange Issues –Topic: Governance**

This is the first of three background memorandums that are designed to assist the Virginia Health Reform Initiative (VHRI) Advisory Council and Task Force members in providing options and recommendations on a Virginia Health Benefit Exchange to the Secretary of Health and Human Resources, Dr. Bill Hazel. Secretary Hazel along with the State Corporation Commission's Bureau of Insurance will work with the Virginia General Assembly, relevant experts, and stakeholders to provide recommendations regarding the governance and structure of the Virginia Health Benefit Exchange for consideration by the 2012 Session of the General Assembly. Final options and recommendations are due to the Governor and General Assembly members by October 1, 2011.

The Health Benefit Exchange (HBE) is the new marketplace for small group and individual insurance. The HBE was envisioned by the Patient Protection and Affordable Care Act (PPACA) and by various state laws (e.g., Massachusetts and Utah) that both preceded and informed PPACA's inclusion of a HBE. The intent of the HBE is to: improve small group and non-group insurance market performance through transparency, provide consumer education about various insurance choices, and provide assistance with eligibility determinations for Medicaid, premium assistance tax credits and cost-sharing reductions. The effect of the HBE, along with the market reforms and subsidies that go with it, should be to substantially increase the number of Virginians with private insurance coverage.

The substantive emphasis in this first of three memorandums is on governance issues. Logically, this should be considered first because the choices about what responsibilities to entrust to an exchange and what checks and balances are most appropriate for the resulting power will in large measure determine the functionality, sustainability, and effectiveness of state and federal reform efforts in the Commonwealth.

Meeting and Public Comment Process on the Virginia Health Benefit Exchange

There will be three meetings with the VHRI Advisory Council on key HBE issues. The Task Force Members are welcome to attend as a member of the audience and provide comment on the discussions. These meetings will be one day meetings at the Department of Medical Assistance Services in Richmond on:

- May 26, 2011,
- July 15, 2011, and
- September 9, 2011

Memorandums will be made available to the public simultaneously with being emailed to the Advisory Council and Task Force members so that it may be useful as an organizing device for public comments any citizen of the Commonwealth or interested party might like to make. We also encourage members of the Council and Task Forces to submit written comments so that the entire spectrum of ideas is collected prior to Advisory Council meetings. All written comments received by the designated time will be compiled and sent to members of the Council and Task Forces approximately two weeks prior to the May 26, 2011 meeting of the VHRI Advisory Council in Richmond. The memorandums and comments received will form the basis of the discussion at the public meeting.

Stakeholders and consumers can provide comments two ways:

- Written public comment will be accepted on a series of memorandums regarding HBE issues. These memorandums will be sent out to all Council and Task Force members and the public several weeks prior to each of the three meetings (they also will be posted on http://www.hhr.virginia.gov/Initiatives/HealthReform). Those who choose to comment will have two weeks to respond. These responses will be provided to the Advisory Council prior to the meeting. We encourage those who submitted comments during the 2010 fall meetings to resubmit their comments if they pertain to the HBE. The memorandums and the written comments will form the basis of the discussion at the three meetings.
    - **The written comments on this April 15, 2011 memorandum are due by 5 p.m. on April 29, 2011.**
    - Written comments will only be received by submission to: VHRI@governor.virginia.gov with the subject line heading: Comment on April 15 Memorandum on Governance.

- Oral public comment will take place at the three Advisory Council meetings held in Richmond, Virginia.

GOVERNANCE ISSUES

This memorandum has been organized into four parts:

I. The Charge (from the 2011Session of the General Assembly), including what the Secretary of Health and Human Resources must include in the report of recommendations to the Governor and the legislature by October 1, 2011,

II. Decisions the Commonwealth must make regarding a health benefit exchange, which will clarify state and federal roles in the construction of the HBE,

III. What other states have done (or are doing) regarding Health Benefit Exchanges, including a brief report on relevant choices others have made or are considering, and,

IV. Potential advantages and disadvantages of different governance structures for a HBE in Virginia, and a guide to the major HBE governance choices that the Governor and legislature will ultimately address in the 2012 legislative session, and beyond. Discussion of the issues raised in this last section will likely claim the bulk of our time together in Richmond on May 26th.

I. The Charge

At the December 13, 2010 meeting of the Virginia Health Reform Initiative Advisory Council, there were two recommendations made regarding the planning for a Health Benefit Exchange. The first recommendation provided the intent to create a Virginia Exchange rather than default to the federal government:

> *Virginia should create and operate its own health benefits exchange to preserve and enhance competition. We suggest the Governor and legislature work together to create a process to work through the various issues in detail, with broad stakeholder input, in time for implementation to satisfy the timing requirements of the federal law.*

The second recommendation provided some basic principles to be part of any Exchange design:

> *Whatever form the Virginia Health Benefit Exchange (HBE) ultimately takes, there is broad agreement about what the HBE should achieve in practice, about what would be considered a successful HBE, and therefore what the Secretary, Legislature and Governor should keep in mind:*
>
> 1. *Provide employers with an opportunity to be successful financially while providing health insurance to their workers*
> 2. *Provide a marketplace that works well for those without insurance today*
> 3. *Provide a marketplace that facilitates the transformation of the delivery system to produce more value per dollar spent, by focusing on quality and transparency*
> 4. *Transparency in all things should promote choice, stability and innovation*
> 5. *The HBE must address the cost of health care and the competitive disadvantage that small firms and ultimately all United States firms labor under now. We should not miss an opportunity to explore how the HBE can help on the cost front.*
> 6. *The HBE should help educate employees and employers through a user-friendly website*
> 7. *Individuals and employees should be engaged in their own care as well as in regular wellness and prevention activities*
> 8. *A goal of the exchange should be to maximize choice, innovation, the number of competing qualified health plans and effective competition with transparency regarding cost and quality in driving consumer decision making.*
> 9. *Long term care insurance should be included in the exchange.*
> 10. *Above all: remember to keep it simple, so that employers and average citizens can understand how to use and benefit from the HBE marketplace.*

The VHRI Advisory Council's recommendations on the Exchange then served as a basis for House Bill 2434 (http://leg1.state.va.us/cgi-bin/legp504.exe?ses=111&typ=bil&val=hb2434) which states the intent of the General Assembly to create a plan for operating a health benefits exchange. This bill directs the Secretary of Health and Human Resources and the State Corporation Commission's Bureau of Insurance, to work with the General Assembly, relevant experts, and general stakeholders to provide recommendations by October 1, 2011, for consideration by the 2012 General Assembly regarding the structure and governance of the Health Benefit Exchange.

The plan for the Virginia Health Benefit Exchange must meet the federal requirements under the Patient Protection and Affordable Care Act. Based on the legislation, the recommendations should address at a minimum:

- Whether to create the HBE within an existing governmental agency, as a new governmental agency, or as a not-for-profit private entity;
- The make-up of the governing board for the HBE;
- An analysis of resource needs and sustainability of such resources for the HBE;
- A delineation of specific functions to be conducted by the HBE; and
- An analysis of the potential effects of the interactions between the Virginia HBE and relevant insurance markets or health programs, including Medicaid.

II. Decisions the Commonwealth Must Make Regarding Health Benefit Exchanges

The implementation of the Patient Protection and Affordable Care Act (PPACA), like that of the State Children's Health Insurance Program (referred to in Virginia as the Family Access to Medical Assistance Services (FAMIS)) (SCHIP), the Health Information Portability and Accountability Act (HIPAA) and Medicaid, is an exercise in federalism, meaning the federal law lays out specific state roles, responsibilities, and choices pursuant to federal law and regulation. What follows is a list of the key decisions the state must make regarding the Health Benefit Exchange. Each decision bullet/question also includes a brief description of any relevant context. The VHRI Advisory Council will focus on these decisions throughout the summer and early fall of 2011.

- Should Virginia create and operate a state Health Benefit Exchange (HBE), or default to a federally run HBE?
    - The US Secretary of Health and Human Services (HHS) will determine, by January 1, 2013, if "adequate progress" is being made in Virginia so that the Virginia HBE is likely to be operational by January 1, 2014 If it is determined that Virginia has not made "adequate progress," then provisions for a federally-operated exchange will be made. The VHRI Advisory Council voted to create a state exchange in its recommendations last December, both to improve the performance of the individual and

small-group insurance markets and to avoid a federal takeover of those markets in Virginia.

- Will the Virginia HBE be located within an existing state agency, a new state agency, or a new non-profit entity?
    - This is the first major "governance" decision, and so will be discussed in more detail in section IV.

- How should Virginia seek to build capacity within the Virginia HBE so that it can remain compliant with federal performance requirements while ensuring that over time Virginia maintains autonomy from the federal government?
    - These requirements include: certify qualified health plans among all potential applicants; operate a toll-free hotline, maintain a web-site, and develop a "navigator" program to aid consumer choice; create a one-stop eligibility determination for individuals who might also be eligible for Medicaid; assign a price and quality rating to all participating health plans; provide an electronic calculator so consumers can predict what each plan will cost them, including both premiums and cost sharing; certify individuals who will be exempt from the individual responsibility requirement due to income or other reasons; share information with Treasury and employers to ensure only eligible individuals are enrolled; report HBE performance data, including the results of enrollee satisfaction surveys as well as administrative costs incurred.

- Should the Virginia HBE be statewide, multi-state, or a set of geographically contiguous sub-state exchanges?
    - The only requirement from PPACA is that the entire state must have access to a HBE, and that HBEs do not compete with each other in the same geographic area.

- Should Virginia combine the non-group and small group risk pools or keep them separate as they are today?
    - There is a natural tradeoff here between minimizing change – since the non-group and small group markets are underwritten and regulated differently under current law – and equity between people with and without an employer offer of health insurance.

- How small is a "small group?"
    - PPACA requires that individuals be eligible to purchase through a HBE: if they are not eligible for Medicaid, Medicare, or other public program; if they do not have an employer offer of qualified health insurance; if they work for "small" employers, assuming the employer elects to use the HBE; if they would have to pay more than certain percentages of income

for premiums under certain conditions in "large" firms or small firms that prefer to remain outside the HBE.
    - States can define "small employers" to be an employer which employs up to 50-100 Full Time Employees (FTEs) for 2014-2016, and have the option to expand the size of the small employer to 100+ FTE's after 2017.

- Should Virginia require more benefits than the "essential benefits package" (EBP)?
    - The Secretary of Health and Human Services (HHS) will issue regulations later this year defining the EBP. The regulations will determine the benefits required of all qualified health plans (QHPs), i.e., those that will be allowed to be sold inside the exchange. All plans sold in the individual and small group markets *outside* the exchange must also include the EBP, but self-insured plans are not required to do so. In the likely event that the EBP does not include all the benefits currently required under Virginia law (Virginia has more benefit mandates than most states), Virginia policy makers will have to decide whether to require benefits in addition to what the EBP does or change existing Virginia law in this regard. There are financial implications to this decision since benefits required by a state, that are beyond what is required by the EBP, may be entirely financed at full cost to the state.

- Should Virginia make all market rules that will be adopted inside the HBE also applicable to the parallel markets (individual and small group) outside the HBE?
    - There are a host of adverse selection risks and remedies under this topic, related to actuarial values, self-insured attachment points, etc., but the general point for now is to note that most remedies for adverse selection involve restrictions on choice and freedom, so understanding the tradeoffs involved will be important.

- Which risk adjustment, reinsurance, and risk corridor methods should Virginia adopt?
    - PPACA requires the federal government to provide technical guidance on these techniques for minimizing adverse selection against the HBE and against plans that attract a disproportionate share of high risk individuals. Virginia's HBE will retain freedom to select the allowed method that makes the most sense for Virginia's insurance markets.

- Should the state incorporate a Virginia-specific version of the "basic health plan" option as a type of "bridge" insurance product for families with incomes that hover but fluctuate near the income dividing line between being eligible for Medicaid and eligible for premium and cost-sharing subsidies inside the HBE?

- Given Virginia's successful track record with Medicaid managed care and the clinical value and cost efficiency of continuous relationships with "usual source of care" providers, this could be good for the Commonwealth, patients, and plans, if the parameters of the option can be structured appropriately.

- Should Virginia encourage or require the HBE to be more of an active purchaser or an open market facilitator?
  - The former would use leverage and managed competition tools to negotiate and narrow options for enrollees, as large employers do today. The latter would be more of a clearinghouse for all legally qualified products and let the small employer and individual marketplaces work as much as possible as they do today.

III. What Other States Have Done Regarding Health Benefit Exchanges

- 49 states (all but Alaska) applied for and received a health benefits exchange planning grant, but Florida and Louisiana have recently indicated that they are ceasing implementation activities, and New Hampshire has delayed an already-agreed upon planning grant contract.

- 7 states – Kansas, Massachusetts, Maryland, New York, Wisconsin, Oklahoma, and Oregon – have received "early innovator" grants to develop HBE-oriented technologies and eligibility determination systems that can serve as models for other states. The University of Massachusetts Medical School, as the grantee, is leading a multi-state New England consortia for Connecticut, Maine, Massachusetts, Rhode Island and Vermont.

- 3 states, California, Maryland, and West Virginia, have enacted legislation to create a new HBE. California's HBE is an independent public entity with a five member board to be appointed by the governor and legislative leaders. Their legislation called for the HBE to become an "active purchaser." Maryland's HBE is a public corporation with attributes of both a government agency and nonprofit having a nine member board of trustees with three ex-officio board members and six members appointed by the governor with the consent of the senate. The HBE for West Virginia will be located within the office of the Insurance Commissioner with a ten member board: four ex-officio members, four appointed by the governor and approved by the senate; one representing insurance carriers and one representing providers.

- With the exception of the above, no other states, accept Massachusetts and Utah, both of whom had versions of HBE's before PPACA passed, have enacted

legislation and therefore made decisions about HBE governance. Utah is considering whether to make their HBE PPACA-compliant (Massachusetts' HBE is almost compliant now and has been explicitly grandfathered in). Of those states who have passed legislation in at least one house of their legislature OR had an official task force make *specific* recommendations about governance:

- 4 are leaning toward an independent governmental or quasi-governmental agency taking the lead, as Massachusetts and California have (NM, OR, MS{senate}, ME),
- 4 have turned planning the HBE over to the Department of Insurance (AL, AR, ID, KA),
- 2 are leaning toward placing the HBE within the Department of Insurance (WV, ND),
- 5 are leaning toward setting up a non-profit to run the HBE (HI, MS{house}, WA, IN, OR),
- None are leaning toward placing the exchange in an existing state agency other than Insurance Department,
- 7 are pursuing or leaning toward the active purchaser model (CA, MA, NM, OR, PA, WA, WI [prior to Gov. Walker]); and,
- 1 is leaning toward the market facilitator model (WI post-Gov. Walker)

The State Coverage Initiative held a webinar on April 14, 2011 on State Approaches to Health Benefit Exchange Legislation, which highlighted how the states of Nevada, Missouri, and Maryland have approached governance issues (http://www.statecoverage.org/node/2999).

IV. Potential Advantages and Disadvantages of Different Governance Structures for a Health Benefit Exchange in Virginia

"Governance" includes questions such as: Where will the HBE be located? Who are the policy-making and administrative officials of the HBE, and how are they chosen? How is the HBE Funded? What types of policy decisions is the HBE empowered to or required to make? What flexibility does the HBE have with regard to personnel, procurement, and other administrative matters?

PPACA does not include any specific option for HBE governance except it must be a either a governmental agency or a nonprofit entity. Generally, there are three options for where the HBE could be located: in an existing governmental agency; create a new governmental agency; or designate a not-for- profit private or quasi-public entity. Possible advantages and disadvantages for each of the location options include:

- Health Benefit Exchange in an existing governmental agency (examples include: Department of Medical Assistance Services (DMAS), State Corporation Commission or Bureau of Insurance (SCC or BOI), Department of Human Resources Management):

- Possible Advantages
  - Direct link to the state administration with established administrative systems and procedures.
  - May have savings from a shared infrastructure.
  - More direct ability to coordinate with other key state agencies, such as DMAS (for integrated eligibility systems across health care programs) and BOI (for oversight and enforcement).
  - Each separate agency has expertise in at least one area of the HBE's operations.
  - Maintaining regulatory authority over a large share of the commercial health insurance market.
  - Promoting state health reform strategies and priorities through the HBE.
- Possible Disadvantages
  - Risk of HBE's decision making and operations being politicized.
  - Difficulty for the HBE to be flexible in hiring and contracting practices, given state personnel and procurement rules.
  - May overwhelm an existing agency and cause intra-agency friction over resources.
  - No existing agency has experience with all of the functions that a HBE will have to perform.
  - May try to fit its new activities into old ways of doing business rather than seek better, innovative solutions.
  - May focus more on the areas most closely related to traditional areas of responsibility and not give enough attention to other tasks of the HBE.
  - Likely to have long-established relationships with certain interest groups and may be insufficiently attentive to the needs and desires of stakeholders with which it has not previously had much contact.
  - Need to strike a balance between the HBE roles (refereeing and possibly structuring competition) and Insurance Department roles (regulation and insuring solvency) with respect to the insurance market.

- Health Benefit Exchange in a New Governmental Agency. Could be an executive department reporting to the Governor/Secretary or independent public entity with its own governing board.
  - Possible Advantages
    - New agency's total focus would be on the HBE functions.
    - Could still be appointed by and responsible to the Governor.
    - Assures a high degree of accountability.
    - Maintaining regulatory authority over a large share of the commercial health insurance market.
    - Promoting state health reform strategies and priorities through the HBE.
  - Possible Disadvantages
    - May be subject to political considerations and fluctuation every 4 years.

        - May be difficult to exempt HBE from state administrative requirements, such as compensation, procurement, rulemaking procedures, and/or open meetings.
        - Require intensive coordination with existing state agencies such as DMAS and BOI.
        - Require high level expertise not available with state compensation rules.
        - Challenge of creating a new program at a time when states are struggling to balance their budgets.

- Health Benefit Exchange as not-for-profit private or quasi-public entity, with an appointed board or commission responsible for decision-making and day-to-day operations
    - Possible Advantages
        - Total focus would be on the HBE functions.
        - May have more independence from politics and fewer turnovers due to change in administrations.
        - Possibility of more flexibility in administrative and operational matters, including compensation package for staff and procurement.
        - With appropriate authorizing statutory requirements, some of the disadvantages listed below could be corrected.
    - Possible Disadvantages
        - Could be more isolated and make it difficult to communicate and coordinate with other state agencies involved in health care reform.
        - State may not want to assign the duties to an organization over which it would have limited control.
        - Some functions are inherently governmental, such as levying taxes or regulating economic activity, and the State may not want to turn over to the entity; some states' laws and constitutions would prohibit this.
        - Could increase the potential for conflicts of interest and heightened scrutiny under the antitrust laws.
        - Could raise privacy questions by giving a non-governmental entity access to personal tax information.

Once the VHRI Advisory Council determines where to recommend that the Health Benefit Exchange should be located, it is also critical to discuss how best to establish an appointed Board or Commission responsible for oversight of decision making and day to day operations. Future Health Benefit Exchange enabling legislation should specify how the Board members would be appointed, including its size, composition and terms. The Board could also select the HBE's Executive Director.

As suggested by the National Association of Insurance Commissioner's draft legislation, called the American Health Benefit Exchange Model Act, Virginia would have to include in its legislation sections relating to governance and operations that set out:

- The appointment process, powers, duties, and other responsibilities of any board, committee or other entity that will have day-to-day responsibility for carrying out the duties and responsibilities of the HBE, as provided in PPACA;
- Authority and procedures for hiring staff and procurement resources; and,
- Responsibilities of State agencies coordinating activities with the HBE.

There are various options for a Governing or Advisory Board, including the three described below.

- Within an existing or new state entity, the Commissioner or Executive Director would have the responsibility for oversight and management of the HBE. An advisory board might be established to provide input and offer advice on the HBE policies and procedures, but ultimate decision making would rest with the agency.
- Create a governing body that is separate and apart from state agencies to serve as policy making body for the HBE.
- Create a governing body that is part of the not-for-profit entity.

The composition of the Governing Bodies or Advisory Boards could include:

- State officials with expertise in Medicaid,
- State officials with expertise in Insurance,
- Secretaries of Health and Human Services, Finance,
- Individuals with commercial health insurance experience,
- Consumer representatives,
- Employer representatives,
- Health service provider representatives,
- Individuals or organizations with experience in individual and/or small group markets,
- Insurance agents and brokers; and,
- Individuals with certain areas of expertise, such as health economics or actuarial science.

Based on their proposed HBE legislation, most states designate certain members, have members appointed by the Governor and/or the Legislature or seek a combination of all. To avoid conflicts of interest, some states may not include persons employed in health insurance or health care (such as California) while other states choose to include that level of expertise on their boards (such as Missouri). Two examples of how Boards are created are found in the Utah and Massachusetts models.

- Massachusetts, which created "the Connector" as a quasi public agency created a Board of Directors, composed of 11 members. The Secretary of Administration and Finance (who also is the Chair), the Director of Medicaid, the Commissioner of Insurance, and the Executive Director of the health benefits agency for state employees all serve as ex-officio members. The balance of the Board is comprised of a mix of stakeholders, including

representatives of small businesses, consumers, and organized labor. In addition, the law requires the appointment of an actuary, a health benefits plan specialist, and a health economist. The law prohibits any representative from a health insurance company from serving on the Board but in 2010, the legislature required that one Board seat be held by an insurance broker.

- Utah, which operates as a state office within the Governor's Office of Economic Development, has a Risk Adjuster Board and an Advisory Board. The Risk Adjuster Board, which manages the risk sharing mechanisms for the Exchange's defined contribution market has its members appointed by the Governor. The Utah law also provides for an advisory board that consists of representatives of state agencies, insures, producers, and consumers.

Please let us know if you have any questions concerning this memorandum or the process established for the VHRI Advisory Council meetings and for public comment. Specific details about the meeting logistics for May 26, 2011 will be forthcoming. Thank you for your service to the Commonwealth of Virginia.